

EMPLOYEE'S REPORT

Claim Number: 150092 ms Date of Injury: 01/19/2015 Date: January 28, 2015

In order for us to complete our investigation and give prompt consideration to your claim, it is necessary for you to fill out this form and return it in the enclosed self-addressed, stamped envelope. **If you have not received an answer from our office regarding the compensability of your claim, the delay is due to the fact that requested medical or other pertinent information has not been received and our investigation is continuing.**

Thank You.

Worker's Compensation Claim Section

Name Shannon Lewandowski SS# 395869784
Address 1632 N. 53rd Milw WI
How long with the City of Milwaukee: Months _____ Years 16 Occupation Detective
Home Phone 414 405-4417 Cell Phone _____ Work Phone _____
Date & Time of Injury 2:15am Jan 19, 15 Type of Injury Concussion
Address Where Injury Occurred 3500 W. North Ave Milw extremely injured
Any employment elsewhere? Yes: ☒ or No: ☒ If yes, where? Part time Marian Union.
In your own words describe what caused your injury (Use back if more space needed)
Intoxicated driver that disregarded the red stop light. See incident report for witness statements 150190017

List dates and hours lost from work due to this injury (include hours lost for doctor's appointments, etc.).
Jan 19, 2015 @ 2:15am → present
It is mandatory that you notify our office when you are returning to work or are losing additional time from work.

Witnesses See Police Report included in 150190017
Describe present complaints, if any neck, back aches, unable to sit long time. Severe headache, short term memory loss, therapy for @ foot, dizziness @ Knee pain
Any previous similar problems? If so, please explain None except for left knee

Did you have surgery? Yes: ☐ or No: ☒ Is surgery scheduled? Yes: ☒ or No: ☐
Doctors' Names Dr. Brian McCarb Address: 3111 W. Rawson Phone: (414) 3846700
Name of Hospital Dr. Jamie Edwards
Dr. Erin O'Toole
Date of First Treatment 1-17-15 Were X-Rays taken Y Fracture
Name & Address of Family Physician Dr. William Shaffer Phone: (414) -----1675

I certify that the above information is true and accurate to the best of my understanding. I understand that filing a fraudulent claim may result in disciplinary action.

Date Feb 1, 2015 Employee's Signature Shannon Lewandowski

USE REVERSE SIDE TO GIVE US ANY ADDITIONAL INFORMATION

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